

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022511

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1775

FILED JUN 11 1963

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		c. CITY OR TOWN <u>Florissant</u> <u>Normandy</u>	
Length of stay in 1b <u>2 1/2</u> days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic Hos.</u>		d. STREET ADDRESS (If outside, give location) <u>Box 6-7701 Florissant Rd.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Bryant</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1-63</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>newborn</u>	9. AGE (last birthday) <u>2 1/2</u> Months <u>2 1/2</u> Days <u>2 1/2</u> Hours <u>2 1/2</u> Min.
11a. FATHER'S NAME <u>Wendell Bryant</u>		11b. MOTHER'S MAIDEN NAME <u>Oleta Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Wendell Bryant 7701 Florissant Rd</u>	
17. INFORMANT <u>Wendell Bryant 7701 Florissant Rd</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rematunty</u> <u>Amputation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Amputation</u> DUE TO (c) <u>Amputation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>5:55</u> a.m. <u>5:55</u> p.m. Month, Day, Year <u>6-1-63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>6-1-63</u>	20f. CITY, TOWN, OR LOCATION <u>6-3-63</u>
21. I attended the deceased from <u>6-1-63</u> to <u>6-3-63</u> and last saw her alive on <u>6-3-63</u> Death occurred at <u>5:55</u> <u>A</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Wendell Bryant</u> (Degree or title) 22b. ADDRESS <u>752 N. Bridge</u> 22c. DATE SIGNED <u>6-4-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/4/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Donaldson Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Donaldson Ark.</u>
24. FUNERAL DIRECTOR <u>Robert Kelly</u>	25. DATE RECD. BY LOCAL REG. <u>6-4-63</u>	26. REGISTRAR'S SIGNATURE <u>John Murphy M.D.</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James A. Lommer

Licensed Embalmer No.

4142

P. O. Address

St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.